		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028605

Facility Name: Rest Haven West Christian Nursing Center

Address: 3450 Saratoga Avenue (Number) Downers Grove (City) 60515 (Zip Code)

County: Du Page

Telephone Number: (630) 969-2000 **Fax #** (630) 969-2148

IDPA ID Number: 362382853003

Date of Initial License for Current Owners: 05/01/84

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501 (C) 3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	145	Skilled (SNF)	145	52,925	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	96	Sheltered Care (SC)	96	35,040	5
6		ICF/DD 16 or Less			6
7	241	TOTALS	241	87,965	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	17,417	20,409	9,189	47,015	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC		30,774		30,774	12
13	DD 16 OR LESS					13
14	TOTALS	17,417	51,183	9,189	77,789	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.43%

D. How many bed-hold days during this year were paid by Public Aid?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 05/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 05/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 145 and days of care provided 9,189

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	681,294	144,027	65	825,386		825,386		825,386			1
2	Food Purchase		466,209		466,209		466,209	(12,235)	453,974			2
3	Housekeeping	179,284	33,731		213,015		213,015		213,015			3
4	Laundry	73,648	18,061		91,709		91,709		91,709			4
5	Heat and Other Utilities			221,713	221,713		221,713	12,115	233,828			5
6	Maintenance	181,164		144,466	325,630		325,630	(13,180)	312,450			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,115,390	662,028	366,244	2,143,662		2,143,662	(13,300)	2,130,362			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	2,915,292	246,334	292,877	3,454,503		3,454,503		3,454,503			10
10a	Therapy			792,700	792,700		792,700	(36,951)	755,749			10a
11	Activities	297,379	18,108	1,705	317,192		317,192		317,192			11
12	Social Services	146,407		2,198	148,605		148,605		148,605			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,359,078	264,442	1,103,880	4,727,400		4,727,400	(36,951)	4,690,449			16
	C. General Administration											
17	Administrative	144,773		430,793	575,566		575,566	(430,793)	144,773			17
18	Directors Fees											18
19	Professional Services			39,853	39,853		39,853	16,789	56,642			19
20	Dues, Fees, Subscriptions & Promotions			32,612	32,612		32,612	7,030	39,642			20
21	Clerical & General Office Expenses	814,428	29,752	55,809	899,989		899,989	42,386	942,375			21
22	Employee Benefits & Payroll Taxes			875,173	875,173		875,173	97,309	972,482			22
23	Inservice Training & Education							860	860			23
24	Travel and Seminar			11,422	11,422		11,422	13,526	24,948			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			102,084	102,084		102,084	7,346	109,430			26
27	Other (specify):*											27
28	**TOTAL General Administration**	959,201	29,752	1,547,746	2,536,699		2,536,699	(245,547)	2,291,152			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,433,669	956,222	3,017,870	9,407,761		9,407,761	(295,798)	9,111,963			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Rest Haven West Christian Nursing Center #0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			573,265	573,265		573,265	250,719	823,984			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			286,353	286,353		286,353	9,533	295,886			32
33	Real Estate Taxes			20,112	20,112		20,112	(12,201)	7,911			33
34	Rent-Facility & Grounds							3,386	3,386			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			879,730	879,730		879,730	251,437	1,131,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		790,443		790,443		790,443		790,443			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,387	79,387		79,387		79,387			42
43	Other (specify):* Nonallowable Costs			320,994	320,994		320,994	(320,994)				43
44	**TOTAL Special Cost Centers**		790,443	400,381	1,190,824		1,190,824	(320,994)	869,830			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,433,669	1,746,665	4,297,981	11,478,315		11,478,315	(365,355)	11,112,960			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,531)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	175,874	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	367	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(188,955)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(224,038)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (251,283)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(114,072)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (114,072)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (365,355)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/2003**

Schedule 5A

VI. ADJUSTMENT DETAIL
LINE 29 - Other

Description	Amount	Schedule V Reference
Recording of Dues	457	20
Residents Welfare	(8,939)	43
Uniform Income Offset	(50)	22
Miscellaneous Income Offset	(11,312)	21
Telephone Income Offset	(1,029)	21
Barber Income Offset	(3,344)	21
Church/Civic	(815)	43
Gift Gratuities	(883)	43
Interehab Physiatry	(69,525)	43
Disallow Real Estate Tax	(20,112)	33
Medicare Laboratory	(42,781)	43
Medicare X-Ray	(9,463)	43
Disallow related party therapy	(36,951)	10A
Disallow out of state travel	(3,062)	24
Capitalize repairs & maintenance	(16,229)	6
Total	**(224,038)**	

See Accountants' Compilation Report

STATE OF ILLINOIS

Rest Haven West Christian Nursing Center

ID# 0028605

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Rest Haven West Christian Nursing Center **#** 0028605 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(14,531)	2,296	0	0	0	0	0	0	0	0	0	(12,235)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	12,115	0	0	0	0	0	0	0	0	0	12,115	5
6	Maintenance	0	3,049	0	0	0	0	0	0	0	0	0	3,049	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(14,531)	17,460	0	0	0	0	0	0	0	0	0	2,929	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(430,793)	0	0	0	0	0	0	0	0	0	(430,793)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	16,789	0	0	0	0	0	0	0	0	0	16,789	19
20	Fees, Subscriptions & Promotions	0	6,572	0	0	0	0	0	0	0	0	0	6,572	20
21	Clerical & General Office Expenses	0	58,071	0	0	0	0	0	0	0	0	0	58,071	21
22	Employee Benefits & Payroll Taxes	0	97,359	0	0	0	0	0	0	0	0	0	97,359	22
23	Inservice Training & Education	0	860	0	0	0	0	0	0	0	0	0	860	23
24	Travel and Seminar	0	16,588	0	0	0	0	0	0	0	0	0	16,588	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,346	0	0	0	0	0	0	0	0	0	7,346	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(227,208)	0	0	0	0	0	0	0	0	0	(227,208)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(14,531)	(209,748)	0	0	0	0	0	0	0	0	0	(224,279)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	175,874	74,846	0	0	0	0	0	0	0	0	0	250,720	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	9,533	0	0	0	0	0	0	0	0	0	9,533	32
33	Real Estate Taxes	0	0	7,911	0	0	0	0	0	0	0	0	7,911	33
34	Rent-Facility & Grounds	0	0	3,386	0	0	0	0	0	0	0	0	3,386	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	175,874	84,379	11,297	0	0	0	0	0	0	0	0	271,550	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(188,588)	0	0	0	0	0	0	0	0	0	0	(188,588)	43
44	**TOTAL Special Cost Centers**	(188,588)	0	0	0	0	0	0	0	0	0	0	(188,588)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(27,245)	(125,369)	11,297	0	0	0	0	0	0	0	0	(141,317)	45

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Rest Haven Illiana Christian Convalescent Home	100	Rest Haven Central	Palos Heights	Holland Home	South Holland	Sheltered Care
		Rest Haven South	South Holland	Village Woods	Crete	Independent Ret.
				Providence Mgmt. & Development Co.	Tinley Park	Management Co.
				Providence Home Health Care	Tinley Park	Home Health

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	2	Dietary	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 2,296	$ 2,296	1
2	V	5	Utilities		Rest Haven Illiana Christian Convalescent Home	100.00%	12,115	12,115	2
3	V	6	Maintenance		Rest Haven Illiana Christian Convalescent Home	100.00%	3,049	3,049	3
4	V	17	Administrative	430,793	Rest Haven Illiana Christian Convalescent Home	100.00%		(430,793)	4
5	V	19	Professional services		Rest Haven Illiana Christian Convalescent Home	100.00%	16,789	16,789	5
6	V	20	Dues, fees & subscriptions		Rest Haven Illiana Christian Convalescent Home	100.00%	6,572	6,572	6
7	V	21	Clerical & general office		Rest Haven Illiana Christian Convalescent Home	100.00%	58,071	58,071	7
8	V	22	Employee benefits		Rest Haven Illiana Christian Convalescent Home	100.00%	97,359	97,359	8
9	V	23	Inservice training & education		Rest Haven Illiana Christian Convalescent Home	100.00%	860	860	9
10	V	24	Travel & seminar		Rest Haven Illiana Christian Convalescent Home	100.00%	16,588	16,588	10
11	V	26	Insurance-prop, liab & malp.		Rest Haven Illiana Christian Convalescent Home	100.00%	7,346	7,346	11
12	V	30	Depreciation		Rest Haven Illiana Christian Convalescent Home	100.00%	74,846	74,846	12
13	V	32	Interest		Rest Haven Illiana Christian Convalescent Home	100.00%	9,533	9,533	13
14	Total			$ 430,793			$ 305,424	$ * (125,369)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	33	Real estate taxes	$	Rest Haven Illiana Christian Convalescent Home	100.00%	$ 7,911	$ 7,911	15
16	V	34	Rent-facility & grounds		Rest Haven Illiana Christian Convalescent Home	100.00%	3,386	3,386	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 11,297	$ * 11,297	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6			N/A - Voluntary Board with no compensation. See attached Schedule 7A								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rest Haven Illiana Christian Conv. Home
Street Address: 18601 North Creek Drive
City / State / Zip Code: Tinley Park, IL 60477
Phone Number: (708) 342-8100
Fax Number: (708) 342-8006

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Dietary	Accumulated cost	66,524,868	15	$ 14,514	$	10,524,656	$ 2,296	1
2	5	Utilities	Accumulated cost	66,524,868	15	76,578		10,524,656	12,115	2
3	6	Maintenance	Accumulated cost	66,524,868	15	19,273		10,524,656	3,049	3
4	19	Professional services	Accumulated cost	66,524,868	15	106,115		10,524,656	16,789	4
5	20	Dues, fees & subscriptions	Accumulated cost	66,524,868	15	41,544		10,524,656	6,572	5
6	21	Clerical & general office	Accumulated cost	66,524,868	15	367,063		10,524,656	58,071	6
7	22	Employee benefits	Accumulated cost	66,524,868	15	564,167		10,524,656	89,255	7
8	22	Employee benefits	Direct cost	1	11	74,415		1	8,104	8
9	23	Inservice training & education	Accumulated cost	66,524,868	15	5,434		10,524,656	860	9
10	24	Travel & seminar	Accumulated cost	66,524,868	15	104,854		10,524,656	16,588	10
11	26	Insurance-prop, liab & malp.	Accumulated cost	66,524,868	15	46,437		10,524,656	7,346	11
12	30	Depreciation	Accumulated cost	66,524,868	15	473,087		10,524,656	74,846	12
13	32	Interest	Accumulated cost	66,524,868	15	60,257		10,524,656	9,533	13
14	32	Interest-Providence	Direct cost	1	1	128,283		1	0	14
15	33	Real estate taxes	Accumulated cost	66,524,868	15	50,004		10,524,656	7,911	15
16	34	Rent-facility & grounds	Accumulated cost	66,524,868	15	21,400		10,524,656	3,386	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,153,425	$		$ 316,721	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Tax Exempt Bonds		X	Additions and renovations	Varies	2/26/97	$ 5,515,700	$ 5,073,950	07/01/12	0.0536	$ 281,102	1
2	Notes		X	Facility Improvements	Varies	Various	763,564	1,113	Various	Variable	5,252	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 6,279,264	$ 5,075,063			$ 286,354	9
	B. Non-Facility Related*											
10								Allocated from Home Office			9,532	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 9,532	14
15	TOTALS (line 9+line14)						$ 6,279,264	$ 5,075,063			$ 295,886	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.		$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2002	$	2
3. Under or (over) accrual (line 2 minus line 1).		$ N/A	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **Allocated from home office**		$ 7,911	6
TOTAL REFUND $ For Tax Year. **(Attach a copy of the real estate tax appeal board's decision.)**			
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,911	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1998	8
	1999	9
	2000	10
	2001	11
	2002	12

Real estate taxes are allocated from a for-profit management company.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Rest Haven West Christian Nursing Center COUNTY Du Page

FACILITY IDPH LICENSE NUMBER 0028605

CONTACT PERSON REGARDING THIS REPORT Bill De Young

TELEPHONE (708) 342-8100 FAX #: (708) 342-8006

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	19-09-01-203-003-0000	New Home Office Building	$ 50,004.00	$ 7,911.00
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 50,004.00	$ 7,911.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? X YES _____ NO ***See Page 8 for Allocation***

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills** ***Real estate taxes are accrued, bill has not yet been received on the new building.***

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 105,900 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's ground
(such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	29,200	1984	$ 339,570	1
2					2
3	TOTALS	29,200		$ 339,570	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	241		1984	1962	$ 86,903	$	40	$	$	$ 86,903	4
5				1972	889,527	22,238	40	22,238		711,616	5
6				1976	34,742	869	40	869		26,939	6
7				1974	7,414	185	40	185		5,550	7
8				1975	55,878	1,397	40	1,397		40,513	8
	Improvement Type**										
9	Improvement			1976	4,115	103	40	103		2,884	9
10	Improvement			1977	33,527	838	40	838		22,626	10
11	Improvement			1980	6,049	151	40	151		3,624	11
12	Improvement			1981	7,380	185	40	185		4,255	12
13	Improvement			1983	22,839	571	40	571		11,991	13
14	Improvement			1984	253,714	9,250	40	9,250		157,403	14
15	Improvement			1985	297,491	7,437	40	7,437		141,303	15
16	Improvement			1986	275,406	6,885	40	6,885		123,930	16
17	Improvement			1987	24,035	601	40	601		10,217	17
18	Improvement			1988	509,896	12,747	40	12,747		203,952	18
19	Improvement			1989	4,381,420	109,536	40	109,536		1,643,040	19
20	Improvement			1989	90,660	2,267	40	2,267		34,005	20
21	Improvement			1990	155,196	3,880	40	3,880		54,320	21
22	Improvement			1991	5,021	126	40	126		1,638	22
23	Improvement			1992	75,453	1,886	40	1,886		22,632	23
24	Improvement			1993	26,281	657	40	657		7,227	24
25	Improvement			1994	16,231	405	40	405		4,050	25
26	Improvement			1995	128,962	3,224	40	3,224		27,404	26
27	Sign and landscaping			1996	4,764	119	40	119		893	27
28	Fence			1996	1,565	40	40	40		300	28
29	Renovate laundry and break rooms			1996	4,400	110	40	110		825	29
30	Whirlpool tubs			1996	20,200	505	40	505		3,787	30
31	Side rail			1996	2,293	57	40	57		428	31
32	Phone system			1996	35,085	877	40	877		14,400	32
33	Parking lot			1997	15,078	377	40	377		2,451	33
34	Landscaping			1997	10,839	271	40	271		1,761	34
35	Dining room renovation			1997	1,193	30	40	30		195	35
36	Hospitality room renovation			1997	34,830	871	40	871		5,661	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Activity / class room renovation	1997	$ 3,476	$ 87	40	$ 87	$	$ 565	37
38	Carpeting	1997	1,521	38	40	38		247	38
39	Railing	1997	500	13	40	13		84	39
40	Laundry / break room renovation	1998	6,864	172	40	172		946	40
41	Compressor	1998	917	92	10	92		506	41
42	Roof repair	1998	2,320	232	10	232		1,276	42
43	Alarm system	1998	1,056	106	10	106		583	43
44	Hospitality room renovation	1998	12,605	316	40	316		1,738	44
45	Carpeting	1998	76,503	7,653	5	7,653		76,503	45
46	Wallpaper	1998	40,287	4,026	5	4,026		40,287	46
47	Roofing	1998	208,749	20,874	10	20,874		93,933	47
48	Therapy room renovation	1999	23,731	2,374	10	2,374		10,683	48
49	Resident room lighting	1999	23,965	2,396	10	2,397	1	10,784	49
50	Phone upgrade	1999	2,470	248	10	248		1,116	50
51	Renovations	1999	47,385	4,738	10	4,738		21,323	51
52	New door on exygen room	1999	1,993	194	10	194		874	52
53	Landscaping	2000	59,350	1,484	40	1,484		5,194	53
54	Benches	2000	2,500	63	40	63		220	54
55	Room 18 renovation , wallcover, painting, tiling and carpet	2000	7,682	768	10	768		2,688	55
56	Therapy room renovation, wallcover, painting and tiling	2000	28,849	2,885	10	2,885		10,097	56
57	Beauty renovation, wallcover, painting, tiling and carpeting	2000	31,764	3,176	10	3,176		11,116	57
58	Common renovation, wallcover, painting, tiling and carpteing	2000	42,312	4,231	10	4,231		14,809	58
59	Kitchen renovation, wallcover, painting and tiling	2000	24,995	2,500	10	2,500		8,750	59
60	HVAC	2000	32,028	3,203	10	3,203		11,210	60
61	Doors	2000	3,300	330	10	330		1,155	61
62	Countertop	2001	654	65	10	65		228	62
63	Sprinkler system	2001	39,878	997	40	997		2,471	63
64	Benches	2001	2,455	61	40	61		153	64
65	Room renovation	2001	1,398,437	63,725	10	139,844	76,119	349,610	65
66	Rehab renovation	2001	98,080	9,808	10	9,808		24,520	66
67	Nirse call system	2001	114,755	11,476	10	11,476		28,690	67
68	Kitchen renovations	2001	3,800	380	10	380		950	68
69	HVAC	2001	3,000	300	10	300		750	69
70	TOTAL (lines 4 thru 69)		$ 9,866,568	$ 337,706		$ 413,826	$ 76,120	$ 4,112,782	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 9,866,568	$ 337,706		$ 413,826	$ 76,120	$ 4,112,782	1
2	Doors	2001	3,187	319	10	319		797	2
3	Office remodeling	2001	35,071	3,507	10	3,507		8,768	3
4	HVAC	2001	28,200	2,820	10	2,820		7,050	4
5	Carpeting	2001	6,612		10	661	661	1,653	5
6	landscaping	2002	25,539	2,554	10	2,554		3,831	6
7	Fence	2002	4,675	468	10	468		703	7
8	Nurse Call Station Renovation	2002	26,950	2,695	40	674	(2,021)	1,011	8
9	HVAC	2002	12,424	1,242	40	311	(932)	466	9
10	Generator	2002	1,845		40	46	46	69	10
11	Renovations	2002	33,960	3,396	40	849	(2,547)	1,273	11
12	New Therapy Addition	2002	73,389	7,339	40	1,835	(5,504)	2,752	12
13	Landscaping	2002	10,400	1,040	40	260	(780)	390	13
14	Repair R3000 System	2002	3,922		40	98	98	147	14
15	Carpeting	2002	9,713		40	243	243	364	15
16	Bathroom remodeling	2003	12,350	309	20	309		309	16
17	Wallcoverings	2003	36,922	462	40	462		462	17
18	Floorcoverings	2003	42,356	529	40	529		529	18
19	Curtains and Blinds	2003	65,815	823	40	823		823	19
20	Landscaping and Fencing	2003	150,886	1,886	40	1,886		1,886	20
21	Parking, Curbs, and Sidewalks	2003	276,160	3,452	40	3,452		3,452	21
22	PT Wing / New Entry / New Admin. Offices	2003	2,227,944	27,849	40	27,849		27,849	22
23	Signage	2003	9,043	452	10	452		452	23
24	Gazebo	2003	5,436	34	20	34		34	24
25	Courtyard Paving	2003	5,810	291	10	291		291	25
26	Shelving	2003	1,328	66	10	66		66	26
27									27
28									28
29									29
30	Allocated from Home Office	2003	656,118			16,978	16,978	25,934	30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 13,632,623	$ 399,239		$ 481,601	$ 82,362	$ 4,204,143	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,647,076	$ 155,807	$ 266,296	$ 110,489	3-10 yrs	$ 2,227,532	71
72	Current Year Purchases	364,386	18,219	18,219		10 yrs	18,219	72
73	Fully Depreciated Assets							73
74	Allocated from Home Office	520,549		56,128	56,128		227,129	74
75	TOTALS	$ 3,532,011	$ 174,026	$ 340,643	$ 166,617		$ 2,472,880	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	1984 Ford Bus	1989	$ 47,590	$	$	$	5	$ 47,590	76
77	Resident care	1995 Chevrolet K20 Truck	1995	22,494				5	22,494	77
78										78
79	Allocated from home office			9,062		1,740	1,740		2,019	79
80	TOTALS			$ 79,146	$	$ 1,740	$ 1,740		$ 72,103	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 17,583,350	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 573,265	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 823,984	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 250,719	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,749,126	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				3,386			6
7	TOTAL				$ 3,386 **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized by the length of the lease N/A . N/A

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10a, C8	hrs	$	6,673	$ 300,293	$	6,673	$ 300,293	1
2	Licensed Speech and Language Development Therapist	L10a, C8	hrs		559	83,821		559	83,821	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C8	hrs		6,757	371,635		6,757	371,635	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				790,443		790,443	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	13,989	$ 755,749	$ 790,443	13,989	$ 1,546,192	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven West Christian Nursing Center
Provider #: 0028605
01/01/03 to 12/31/03

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
	L39, C3			
	L39, C3			
	L39, C3			
	L39, C3			
Total			0	0

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,200	$ 1,200	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 163,600)	1,691,764	1,691,764	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	14,143	14,143	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,707,107	$ 1,707,107	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	358,918	339,570	13
14	Buildings, at Historical Cost	13,795,156	13,632,623	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	3,319,787	3,611,157	16
17	Accumulated Depreciation (book methods)	(7,136,037)	(6,749,126)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,337,824	$ 10,834,224	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,044,931	$ 12,541,331	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,475,126	$ 1,475,126	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,113	1,113	29
30	Accrued Salaries Payable	87,913	87,913	30
31	Accrued Taxes Payable (excluding real estate taxes)	3,926	3,926	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Schedule 17A	6,872,786	6,872,786	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 8,440,864	$ 8,440,864	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable		5,073,950	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,073,950	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 8,440,864	$ 13,514,814	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,604,067	$ (973,483)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,044,931	$ 12,541,331	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/2003**

Schedule 17A

XV. BALANCE SHEET

C. Current Liabilities **Line 36, Other Current Liabilities (specify):**	Operating	After Consolidation
Dental Withholding	792	792
Health Insurance Withholding	12,361	12,361
TDA Withholding	39,739	39,739
Money Life Insurance Withholding	(247)	(247)
Life Insurance Withholding	(282)	(282)
Standard Withholding	3,820	3,820
Child Support Withholding	7,883	7,883
T.S.A. Withholding	3,827	3,827
Misc. Payroll Withholding	(1,313)	(1,313)
Levy	(3,289)	(3,289)
Life Line Deposits	600	600
Due to Related Parties	6,808,895	6,808,895
Total	6,872,786	6,872,786

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,391,865	1	
2	Restatements (describe):		2	
3	**Prior Period Adjustments**	53,184	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,445,049	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	159,018	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 159,018	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,604,067	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 10,133,286	1
2	Discounts and Allowances for all Levels	(2,449,899)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,683,387	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,884,718	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,884,718	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	11,679	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	737,783	17
18	Sale of Supplies to Non-Patients	27,222	18
19	Laboratory	82,704	19
20	Radiology and X-Ray	10,370	20
21	Other Medical Services	180,883	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,050,641	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	See Schedule 19A	18,587	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 18,587	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,637,333	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,143,662	31
32	Health Care	4,727,400	32
33	General Administration	2,536,699	33
	B. Capital Expense		
34	Ownership	879,730	34
	C. Ancillary Expense		
35	Special Cost Centers	1,111,437	35
36	Provider Participation Fee	79,387	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,478,315	40
41	**Income before Income Taxes (line 30 minus line 40)****	159,018	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 159,018	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name **Rest Haven West Christian Nursing Center**
PROVIDER # **0028605**
Period Ending **12/31/2003**

Schedule 19 A

XVII. INCOME STATEMENT
E. Other Revenue

	Amount
Laundry	126
Food/Vending	1,195
Other Income	10,691
Uniform Income	50
Employee Meals	1,657
Telephone	1,029
Beauty/Barber Income	3,344
Miscellaneous Service Income	495
Total	18,587

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,936	2,160	$ 69,674	$ 32.26	1
2	Assistant Director of Nursing	504	504	14,180	28.13	2
3	Registered Nurses	34,584	37,092	914,710	24.66	3
4	Licensed Practical Nurses	19,926	21,706	456,657	21.04	4
5	Nurse Aides & Orderlies	104,773	111,241	1,440,225	12.95	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,992	2,160	39,751	18.40	9
10	Activity Assistants	20,590	22,579	257,628	11.41	10
11	Social Service Workers	6,913	7,573	146,407	19.33	11
12	Dietician	1,968	2,160	59,648	27.61	12
13	Food Service Supervisor	1,990	2,150	41,483	19.29	13
14	Head Cook	13,266	14,165	182,000	12.85	14
15	Cook Helpers/Assistants	36,043	39,160	398,163	10.17	15
16	Dishwashers					16
17	Maintenance Workers	12,312	13,193	181,164	13.73	17
18	Housekeepers	15,550	16,791	179,284	10.68	18
19	Laundry	6,805	7,124	73,648	10.34	19
20	Administrator	2,080	2,080	83,983	40.38	20
21	Assistant Administrator	2,080	2,080	60,790	29.23	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	38,755	40,342	814,428	20.19	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,392	1,425	19,846	13.93	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	323,459	345,685	$ 5,433,669 *	$ 15.72	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 65	L1, C3	35
36	Medical Director	Monthly	14,400	L9, C3	36
37	Medical Records Consultant	Monthly	4,128	L10, C3	37
38	Nurse Consultant	Monthly	4,843	L10, C3	38
39	Pharmacist Consultant	Monthly	1,740	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	1,705	L11, C3	44
45	Social Service Consultant	Monthly	1,868	L12, C3	45
46	Other(specify) Chapel Ministry	8	330	L12, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	56	$ 29,079		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,503	$ 174,259	L10, C3	50
51	Licensed Practical Nurses	2,634	101,683	L10, C3	51
52	Nurse Aides	16	1,599	L10, C3	52
53	TOTAL (lines 50 - 52)	6,153	$ 277,541		53

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Catherine DeVries	Administrator	0	$ 83,983
Linda Hart	Asst. Admin.	0	60,790
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 144,773

B. Administrative - Other

Description	Amount
Management fees (eliminated in column 7)	$ 430,793
TOTAL (agree to Schedule V, line 17, col. 3)	$ 430,793
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Altschuler, Melvoin		$
& Glasser LLP	Accounting	8,450
Laner, Muchin, Dombrow	Legal	6,868
KPMG Peat Marwick LLP	Accounting	8,360
Alternative Staffing Resource	Consulting	6,472
ProStaff	Consulting	9,445
Michael Best & Friedrich	Legal	258
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 39,853

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 113,326
Unemployment Compensation Insurance	26,629
FICA Taxes	369,065
Employee Health Insurance	259,847
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Drug Testing	4,019
Uniforms	2,463
Employee Education	517
TDA Expense	94,805
Employee Welfare	4,502
Allocated from Home Office	97,309
TOTAL (agree to Schedule V, line 22, col.8)	$ 972,482

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	6,001
Health Care Worker Background Check	
(Indicate # of checks performed 2)	14
Life Services Network	20,132
Wellspring Innovative Solutions	4,279
Miscellaneous Licenses and Dues	2,368
Miscellaneous Subscriptions	276
Allocated from Home Office	6,572
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 39,642

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	8,360
Seminar Expense	
Home Office Allocation	16,588
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 24,948

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Rest Haven West Christian Nursing Center
Provider #: 0028605
01/01/03 to 12/31/03

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)		39,853
Allocated from Management Company	**Legal**	5,170
Allocated from Management Company	**Other**	11,619
Total (agree to Schedule V, line 19, column 8)		56,642

See Accountants' Compilation Report

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4	N/A												
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Rest Haven West Christian Nursing Center # 0028605 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN: $20,132**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **0** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **79,387**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **12,034**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **KPMG Peat Marwick LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit in Progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Rest Haven West Christi** **01:04 PM** **11/4/2005**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-365,355	equal to	-365,355	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	295,886	equal to	295,886	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	7,911	equal to	7,911	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	823,984	equal to	823,984	0	FAILED	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	3,386	equal to	3,386	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	755,749	equal to	792,700	-36,951	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	790,443	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	2,143,662	equal to	2,143,662	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	4,727,400	equal to	4,727,400	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	2,536,699	equal to	2,536,699	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	879,730	equal to	879,730	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	1,111,437	equal to	1,111,437	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	79,387	equal to	79,387	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	2,915,292	equal to	2,915,292	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	297,379	equal to	297,379	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	146,407	equal to	146,407	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	681,294	equal to	681,294	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	181,164	equal to	181,164	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	179,284	equal to	179,284	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	73,648	equal to	73,648	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	144,773	equal to	144,773	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	814,428	equal to	814,428	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	5,433,669	equal to	5,433,669	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	65	< or = to	65	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	14,400	< or = to	14,400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	288,252	< or = to	292,877	-4,625	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	1,705	< or = to	1,705	0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	1,868	< or = to	2,198	-330	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	144,773	equal to	144,773	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	430,793	equal to	430,793	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	39,853	equal to	39,853	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	972,482	equal to	972,482	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	39,642	equal to	39,642	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	24,948	equal to	24,948	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	79,387	equal to	79,387	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	97,309	-97,309	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	9,189	equal to	9,189	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	-114,072	equal to	-114,072	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	5,075,063	equal to	5,075,063	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	339,570	equal to	339,570	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	13,632,623	equal to	13,632,623	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	3,611,157	equal to	3,611,157	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	6,749,126	equal to	6,749,126	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	3,604,067	equal to	3,604,067	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	159,018	equal to	159,018	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	12,044,931	equal to	12,044,931	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses	**YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK**						
	TO THE COST REPORT!!		11/4/2005	01:04:57 PM			
HSA Number	7	Name	**Rest Haven West Christian Nursing Center**				
Cost report period	From:	01/01/03	To:	12/31/03	Base Number	336	
If this is an ICF/DD 16 facility, enter a 1 in cell C		N					
Licensed bed days:	87,965	Occupancy:	77,789	Pct. of occupancy:	88.43%		
Illinois Public Aid Support Rate		$					
Genl Services Salary/Wage:	1,115,390	Col 1, Line 8 ---Audit Adj:					
Genl Admin Salary/Wage	959,201	Col 1, Line 28 ---Audit Adj:					
Total Salary Wage	5,433,669	Col 1, Line 44 ---Audit Adj:					
Employee Benefits	972,482	Col 8, Line 22 ---Audit Adj:					
Total General Services:	2,130,362	Col 8, Line 8 ---Audit Adj:					
Total General Admin	2,291,152	Col 8, Line 28 ---Audit Adj:					

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$1,115,390
Divided by Total Wages (Column 1, Line 44	$5,433,669
General service wages as percent of total wages	20.5274%
Employee Benefits (Column 10, Line 22	$972,482
Allocation of Employee Benefits to General Services Costs	$199,625
Plus Total General Services (Column 10, Line 8	$2,130,362
New Total General Services Cost	$2,329,987

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$959,201
Divided by Total Wages (Column 1, Line 45	$5,433,669
General administration wages as a percent of total wages	17.6529%
Employee Benefits (Column 10, Line 22	$972,482
Allocation of Emplayee Benefits to General Admin. Cost	$171,671
Plus Total General Administration (Column 10, Line 2	$2,291,152
Minus Total Fringe (Column 10, Line 22	$972,482
New Total General Administration Cos	$1,490,341

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13	divided by 2 =	6.5
Beginning Day + Ending Day	32	divided by 60.8 =	0.526315789
Beginning Year + Ending Year =	206	multiplied by 6 =	1236
Sum of the three lines			1243.026316
Subtract from the sum			907.00
Base Number (expressed as a whole number, fraction dropped)			336

B. Select the Appropriate Inflation Multipliers

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$2,329,987	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$2,329,987

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$1,490,341	
General Administration Multiplier (Step II-E	1	
Updated General Services Cost		$1,490,341
3 Total Updated Support Costs (1 + 2		$3,820,328

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO	$48.28

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$3,820,328
Total Patient Days (Cost Report	77,789
Support Costs per Diem	$49.11

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	87,965
Multiplied by	0.93
	81,807
Minus total Patient Days	77,789
	4,018
One-third of difference	1,339
Plus Total Patient Day	77,789
Adjusted Occupancy	79,128
Total Support Costs (Step II, C, 3, above	$3,820,328
Divided by Adjusted Occupany	79128
Support Costs Per Diem	$48.28

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$43.80
Minus Support Costs Per Dier	$48.28
Difference	-$4.48
Multiply the Difference by	0.5
One-Half of the Difference	-$2.24
Plus Support Costs Per Dier	$48.28
Support Rate if costs are between 35th and 75th percentile	46.04

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$43.80
Minus Support Costs Per Dier	$48.28
Difference	-$4.48
Multiply the Difference by	0.5
One-Half of the Difference	-$2.24
Compare one-half the difference to the profit ceiling for your HSA in Table II and	6.07
Enter the Lower of the Two Amounts	-$2.240
Plus Support Costs Per Dier	$48.28
Support Rate if support costs less than 35th percentile	$46.04

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **$43.80**

75th Percentile is	$43.80
35th Percentile is	$31.76

Table
Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)
SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/4/2005 01:04:57 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Rest Haven West Christian Nursing Center** ID: **0028605**

HSA No.: ? Own or Rent? (O or R) ______ Own or Rent Beginning: ______

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): or since the first day of operation for buildings constructed since January 1, 1978? N

Cost Report Pd:		Licensed Beds:	241	Total Patient Days	77,789
Begin	**01/01/03**	Licensed Bed Days:	87,965	% Occupied	88.43%
End	**12/31/03**			Capital Days	81,807

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1993
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	13632623
2. Total licensed beds from cost report Page 2, Line 7, column 3	241
3. Line 1 divided by Line 2	$56,567
4. Regional construction inflator from Table 2	#N/A
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	#N/A
C. Obtain the Uniform Building Value from Table 1	#VALUE!
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	#N/A
2. Uniform building value from Line C	#VALUE!
3. Add Lines 1 and 2	#VALUE!
4. Divide by 2 to obtain average	#VALUE!
5. Enter 120% of line C	#VALUE!
6. The blended value is the lesser of Line 4 or Line 5	#VALUE!
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	#VALUE!
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	#VALUE!
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	#VALUE!
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0

J. Property Tax
Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:

1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	81,807
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	#N/A
5. Equals: Updated Property Tax Cost	#N/A

Capital Days
The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)

1. Total Patient Days	77,789
2. Total Licensed Bed Days * .93	81807
3. Capital Days (higher of Line 1 or Line 2)	81,807

K. Total Capital Rate for FY 94

1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	#VALUE!
2. Add Property Tax from Line J5	#N/A
3. Total capital rate (add Lines 1 & 2)	#VALUE!

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	62	86903	5387986	12
2	2	72	889527	64045944	12
3	3	76	34742	2640392	12
4	4	74	7414	548636	12
5	5	75	55878	4190850	12
6	6	76	4115	312740	12
7	7	77	33527	2581579	12
8	8	80	6049	483920	12
9	9	81	7380	597780	12
10	10	83	22839	1895637	12
11	11	84	253714	21311976	12
12	12	85	297491	25286735	12
13	13	86	275406	23684916	12
14	14	87	24035	2091045	12
15	15	88	509896	44870848	12
16	16	89	4381420	389946380	12
17	17	89	90660	8068740	12
18	18	90	155196	13967640	12
19	19	91	5021	456911	12
20	20	92	75453	6941676	12
21	21	93	26281	2444133	12
22	22	94	16231	1525714	12
23	23	95	128962	12251390	12
24	24	96	4764	457344	12
25	25	96	1565	150240	12
26	26	96	4400	422400	12
27	27	96	20200	1939200	12
28	28	96	2293	220128	12
29	29	96	35085	3368160	12
30	30	97	15078	1462566	12
31	31	97	10839	1051383	12
32	32	97	1193	115721	12
33	33	97	34830	3378510	12
34	34	97	3476	337172	12A
35	35	97	1521	147537	12A
36	36	97	500	48500	12A
37	37	98	6864	672672	12A
38	38	98	917	89866	12A
39	39	98	2320	227360	12A
40	40	98	1056	103488	12A
41	41	98	12605	1235290	12A
42	42	98	76503	7497294	12A
43	43	98	40287	3948126	12A
44	44	98	208749	20457402	12A
45	45	99	23731	2349369	12A
46	46	99	23965	2372535	12A
47	47	99	2470	244530	12A
48	48	99	47385	4691115	12A
49	49	99	1993	197307	12A
50	50	100	59350	5935000	12A
51	51	100	2500	250000	12A
52	52	100	7682	768200	12A
53	53	100	28849	2884900	12A
54	54	100	31764	3176400	12A
55	55	100	42312	4231200	12A
56	56	100	24995	2499500	12A
57	57	100	32028	3202800	12A
58	58	100	3300	330000	12A
59	59	101	654	66054	12A
60	60	101	39878	4027678	12A
61	61	101	2455	247955	12A
62	62	101	1398437	141242137	12A
63	63	101	98080	9906080	12A
64	64	101	114755	11590255	12A
65	65	101	3800	383800	12A
66	66	101	3000	303000	12A
67	67	101	3187	321887	12B
68	68	101	35071	3542171	12B
69	69	101	28200	2848200	12B
70	70	101	6612	667812	12B
71	71	102	25539	2604978	12B
72	72	102	4675	476850	12B
73	73	102	26950	2748900	12B
74	74	102	12424	1267248	12B
75	75	102	1845	188190	12B
76	76	102	33960	3463920	12B
77	77	102	73389	7485678	12B
78	78	102	10400	1060800	12B
79	79	102	3922	400044	12B
80	80	102	9713	990726	12B
81	81	103	12350	1272050	12B
82	82	103	36922	3802966	12B
83	83	103	42356	4362668	12B
84	84	103	65815	6778945	12B
85	85	103	150886	15541258	12B
86	86	103	276160	28444480	12B
87	87	103	2227944	229478232	12B
88	88	103	9043	931429	12B
89	89	103	5436	559908	12B
90	90	103	5810	598430	12B
91	91	103	1328	136784	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	103	656118	67580154	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

1271318450 13632623 93.25560092

Base Year = 1993

TABLE 1 error

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 #N/A

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	681,294	144,027	65	825,386	0	825,386	0	825,386
2. Food Purchase	0	466,209	0	466,209	0	466,209	-12,235	453,974
3. Housekeeping	179,284	33,731	0	213,015	0	213,015	0	213,015
4. Laundry	73,648	18,061	0	91,709	0	91,709	0	91,709
5. Heat and Other Utilities	0	0	221,713	221,713	0	221,713	12,115	233,828
6. Maintenance	181,164	0	144,466	325,630	0	325,630	-13,180	312,450
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	1,115,390	662,028	366,244	2,143,662	0	2,143,662	-13,300	2,130,362
9. Medical Director	0	0	14,400	14,400	0	14,400	0	14,400
10. Nursing & Medical Records	2,915,292	246,334	292,877	3,454,503	0	3,454,503	0	3,454,503
10a. Therapy	0	0	792,700	792,700	0	792,700	-36,951	755,749
11. Activities	297,379	18,108	1,705	317,192	0	317,192	0	317,192
12. Social Services	146,407	0	2,198	148,605	0	148,605	0	148,605
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	3,359,078	264,442	1,103,880	4,727,400	0	4,727,400	-36,951	4,690,449
17. Administrative	144,773	0	430,793	575,566	0	575,566	-430,793	144,773
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	39,853	39,853	0	39,853	16,789	56,642
20. Fees, Subscriptions & Promotion	0	0	32,612	32,612	0	32,612	7,030	39,642
21. Clerical & General Office	814,428	29,752	55,809	899,989	0	899,989	42,386	942,375
22. Employee Benefits & Payroll	0	0	875,173	875,173	0	875,173	97,309	972,482
23. Inservice Training & Education	0	0	0	0	0	0	860	860
24. Travel and Seminar	0	0	11,422	11,422	0	11,422	13,526	24,948
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	102,084	102,084	0	102,084	7,346	109,430
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	959,201	29,752	1,547,746	2,536,699	0	2,536,699	-245,547	2,291,152
29. Total General Administrative	5,433,669	956,222	3,017,870	9,407,761	0	9,407,761	-295,798	9,111,963
30. Depreciation	0	0	573,265	573,265	0	573,265	250,719	823,984
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	286,353	286,353	0	286,353	9,533	295,886
33. Real Estate	0	0	20,112	20,112	0	20,112	-12,201	7,911
34. Rent - Facility & Grounds	0	0	0	0	0	0	3,386	3,386
35. Rent - Equipment & Vehicles	0	0	0	0	0	0	0	0
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	879,730	879,730	0	879,730	251,437	1,131,167
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	790,443	0	790,443	0	790,443	0	790,443
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	79,387	79,387	0	79,387	0	79,387
43. Other (specify):*	0	0	320,994	320,994	0	320,994	-320,994	0
44. Total Special Cost Ce	0	790,443	400,381	1,190,824	0	1,190,824	-320,994	869,830
45. Grand Total	5,433,669	1,746,665	4,297,981	11,478,315	0	11,478,315	-365,355	11,112,960

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	1,200	1,200
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,691,764	1,691,764
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	14,143	14,143
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,707,107	1,707,107
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	358,918	339,570
14. Buildings, at Historical Cost	########	13,632,623
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	3,319,787	3,611,157
17. Accumulated Depreciation (book methods)	-7,136,037	-6,749,126
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	0	0
24. Total Long-Term Assets	########	10,834,224
25. Total Assets	########	12,541,331
CURRENT LIABILITIES		
26. Accounts Payable	1,475,126	1,475,126
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	1,113	1,113
30. Accrued Salaries Payable	87,913	87,913
31. Accrued Taxes Payable	3,926	3,926
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	6,872,786	6,872,786
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	8,440,864	8,440,864
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	5,073,950
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	5,073,950
46.Total Liabilities	8,440,864	13,514,814
47.Total Equity	3,604,069	-973,483
48.Total Liabilities and Equity	########	12,541,331

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	10,133,286
2. Discounts and Allowances for all Levels	-2,449,899
Subtotal - Inpatient Care	7,683,387
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	2,884,718
7. Oxygen	0
Subtotal - Anciliary Revenue	2,884,718
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	11,679
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	737,783
18. Sale of Supplies to Non-Patients	27,222
19. Laboratory	82,704
20. Radiologyand X-Ray	10,370
21. Other Medical Services	180,883
22. Laundry	0
Subtotal - Other Operating Revenue	1,050,641
24. Contributions	0
25. Interest and Other Investments Income	0
Subtotal - Non-Operating Revenue	-
27. Other Revenue (specify):	18,587
28. Other Revenue (specify):	0
Subtotal - Other Revenue	18,587
30. Total Revenue	11,637,333
31. General Services	2,143,662
32. Health Care	4,727,400
33. General Administration	2,536,699
34. Ownership	879,730
35. Special Cost Centers	1,111,437
35. Provider Participation Fee	79,387
37. Other	0
40. Total Expenses	11,478,315
41. Income Before Income Taxes	159,018
42. Income Taxes	0
43. Net Income or Loss for the Year	159,018

Page	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	Provider Participation fee is linked from page 4